

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145809	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/15/2024
NAME OF PROVIDER OR SUPPLIER Grove of Northbrook,the		STREET ADDRESS, CITY, STATE, ZIP CODE 263 Skokie Boulevard Northbrook, IL 60062	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35432</p> <p>Based on interview and record review, the facility failed to monitor a resident during a change in mental condition. This resident was able to injure a resident by pushing a wheelchair aggressively, causing this resident to slide out of the wheelchair hurting her back. The failure affects one of three residents (R1) reviewed for resident-to-resident physical assault.</p> <p>Findings include:</p> <p>R1 is a [AGE] year-old female. R1's face sheet diagnoses are but not limited to high cholesterol, schizoaffective disorders, paranoid schizophrenia, and sciatica. R1's BIMS (Brief Interview for Mental Status), dated 07/18/2024, notes R1 is alert.</p> <p>R3 is a [AGE] year-old male. R3's face sheet diagnoses are but not limited to major depressive disorder, and bipolar disorder. R3's BIMS (Brief Interview for Mental Status), dated 06/06/2015, notes R3 is alert.</p> <p>On 09/14/2024, at 12:09 PM, V1 (Assistant Administrator) stated, (R3) is no longer in the facility. He went to a different nursing facility. He had never had any behavioral concerns. To my knowledge, he did not present with any changes in condition. I was in the building. I heard noises. I went into the hallway. I was told by my Social Services Department that (R3) was upset. I was told he had head butted staff. I was told that he may have gone into someone's room. 911 came. They took over from there. He was on a one to one. But the staff he head-butted was sent to the urgent care. No staff witnessed the incident between (R1) and (R3).</p> <p>On 09/14/2024, at 12:31 PM, R2 stated, (R3) pulled (R1) out of the wheelchair and put the wheelchair over her while she was down. (R3) had a tendency of yelling. (R1) was going to tell (R3) to keep it down. When (R1) went to tell (R3) to keep it down, (R3) yelled fu***** b****. Keep your mouth shut and stay out of my business. (R1) was sitting in the wheelchair, and she fell on the floor. She hit her back on the floor. I was scared because I thought I would be next. Staff was not too far, but it took them about five minutes to assess the situation. I was not hurt; it was just her. I heard him yelling before this occurred. It was like (R3) was not satisfied being in the facility, but he was very agitated. I do not feel safe here because there are other people that are here that must be watched and get agitated.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/14/2024, at 12:42 PM, R1 stated, (R3) was insulting to staff and tried to hit them. He was screaming. He was taking resident's lunches and throwing him. I went over to see what I could do. He got really enraged and he slammed my wheelchair into the bathroom door so hard that me and my wheelchair tipped over. I landed on my back and bottom. Social Services were in the hallway. The nurse came and put me in the chair. My back still hurts from the incident.</p> <p>On 09/14/2024, at 1:31 PM, V2 (Social Worker) stated, I was with (R3) for the one to one. The paramedics and my co-worker were there. Out of nowhere he became aggressive, and head butted me. I went straight to the office and stayed away from the situation. The purpose of a one to one to make sure they do not harm themselves or anyone else.</p> <p>On 09/15/2024, at 4:22 PM, V3 (Admissions Director) stated, I was monitoring (R3) after the staff member got hurt. I wanted to keep my distance, but also monitor him at the same time. I was trying to calm him down, and I spoke with him to keep tensions low. He was saying that he was very angry and going to residents' rooms and closing their doors. I cannot hold him down. I was unaware that any other resident was affected by this. I did not witness this incident.</p> <p>On 09/15/2024, at 4:30 PM, V4 (Social Worker) stated, I was at the front desk covering for the receptionist. (R3) had an independent pass. He was asking me to buy conditioner with my own debit card. I told him that I cannot do that. He got very agitated by that. He got angry and slammed open one of the doors. I contacted our Social Services Director. I was in the office with other staff. He came into the office where we were and said he wanted to leave. That is when (V1) stepped in and asked why he wanted to leave. Staff started (R3's) petition to a local hospital. When the ambulances came, he was in his room. Four of us went to go see what was happening with the paramedics. The paramedics stated that they needed help because he did not want to leave. (R3) went up to (V2) aggressively and he head butted her. I saw it happen. I stepped in and asked why he would do that. He ran into his room again and slammed the door. I grabbed (V2) and took her to the office. (R3) got out of his room and pinned (V3) to the wall. Everything happened so quickly. I had my eyes on (R3). When (R3) started getting aggressive, I could not see everything that was going on. The police ended up coming when he was in his room. Me and (V3) were there, but as soon as he flipped the stretcher and the housekeeping cart, I got startled. I did not see (R3) harm any residents. I have only been on a one to one, one other time. I have just been told to keep an eye on residents and make sure they do not get physical with others.</p> <p>On 09/15/2024, at 4:44 PM, V5 (Licensed Practical Nurse) stated, I did not witness the incident between (R1) and (R3). When I started my shift, (R3) was quiet. I did not notice any behavior. I witnessed him trying to shut residents' doors in the hallway and him hitting one of our staff. Not too long after that, I was informed by staff that (R1) was on the floor. I entered the room and (R1) was sitting on the floor. The wheelchair was behind or beside her. I asked her what happened. She claimed that (R3) pushed her wheelchair while trying to close her door. I asked her if he went inside her room. She said no. She was sitting near her door in her wheelchair. He was trying to close the door. According to her, he pushed her wheelchair. She sits towards the end of her wheelchair. She informed me that she lost her balance and fell out of the wheelchair. I did a head-to-toe assessment. She had a small size discoloration on her right arm and her low back. She denied hitting her head. She fell on her butt. She complained of generalized pain. She is alert and oriented and make her needs known.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>General progress note, dated 08/13/2024, R1 returned to facility around 7:15 PM via ambulance/cart. R1 is alert and approachable. Resident complained of pain to the lower back and buttocks. Skin assessment done with skin discoloration noted to the right upper arm. Right elbow has light purple discoloration.</p>